

**BOARD OF REGISTERED NURSING**

P.O. BOX 944210, SACRAMENTO, CA 94244-2100
 TDD (916) 322-1700
 TELEPHONE (916) 322-3350
 www.rn.ca.gov



NURSE MIDWIFE FURNISHING NUMBER APPLICATION
FEE \$50.00

PERSONAL DATA (Please print or type)			
1. NAME: Last First Middle			Previous Names (Including Maiden):
2. ADDRESS OF RECORD: Number and Street		3. BIRTHDATE:	
City State Zip Code		Month Day Year	
5. TELEPHONE NUMBER: Home: () Work: ()		4. SOCIAL SECURITY NUMBER (Mandatory):	
6. MOTHER'S MAIDEN NAME:			
7. RN LICENSE NUMBER:	8. BRN NMW NUMBER:	9. SPECIALTY:	
PHARMACOLOGY COURSE Complete the section which applies to the type of course you completed.			
10. ACADEMIC COURSE - SCHOOL NAME:		11. COURSE TITLE:	12. COMPLETION DATE:
13. SCHOOL ADDRESS: Number and Street		City, State & Zip Code	14. No. QTR/SEM UNITS:
15. CONTINUING EDUCATION PROVIDER NAME:		16. COURSE TITLE:	17. COMPLETION DATE:
18. CE PROVIDER ADDRESS: Number & Street		City, State & Zip Code	
19. CE PROVIDER NUMBER:		20. TOTAL CE HOURS:	
Documentation required: The school or CE provider must submit the "Pharmacology Course Verification" form. If the course was completed more than four (4) years ago, you must also have a "Verification of Recent Furnishing Experience" form submitted by the agency where the recent furnishing experience was obtained.			
PHYSICIAN SUPERVISED EXPERIENCE			
21. PHYSICIAN NAME:		22. LICENSE NO.:	23. SPECIALTY:
24. AGENCY NAME:		25. TELEPHONE NO.: ()	
26. ADDRESS: Number & Street		City, State & Zip Code	
27. PERIOD OF SUPERVISED EXPERIENCE: From (mo/yr): To (mo/yr):			
Number of Weeks: Hours Per Week: = Total No. of Hours:			
Documentation Required: The physician supervisor must submit the "Verification of Supervised Furnishing Experience" form.			

I certify, under the penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

APPLICANT SIGNATURE: _____ DATE: _____